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ABSTRACT

In the early 1990s, a restructuring of the health services system of Alberta (Canada) amalgamated public health units and hospital districts into 17 Regional Health Authorities. Many of the regions have pursued community grant initiatives in addition to their regular funding, and it seemed that there would be value in comparing the experiences of different regions to share lessons, identify successful processes, and note some of the likely outcomes of such initiatives. Four regions committed to this study. In all four regions, the majority of projects were focused on lifestyle and behavior choices, personal coping skills, and social support. Most of the programs could be characterized as health education or awareness, and none appeared to be primarily concerned with political action or policy advocacy. The nature of the application and funding processes developed in the regions varied so much that systematic comparison is difficult. Two aspects were chosen for comparison: decision-making and training and support. Different types of outcome evaluations were required in the regions, but in general the evaluations could be grouped into studies of impacts on health, increases in the ability of the community to address health concerns, and increases in partnerships and collaboration. The differing approaches make it difficult to say anything about best practices, but it is apparent that the regions continue to engage in a community granting process in one form or another. (Contains 11 references.) (SLD)

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Lessons from a Comparative Study of Community Grant Programs in Alberta Health Authorities[1]

A paper prepared for the 1998 Canadian Evaluation Society conference
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I. Background

A major restructuring of the health services system in Alberta took place in the early 1990s. 27 public health units and over 200 hospital districts were amalgamated into 17 Regional Health Authorities. These RHAs were given the responsibility of providing their residents with a comprehensive array of health services.

Each RHA receives block funding from the province, which it can allocate among different service priorities according to local need and preference. There is one significant exception, however; in 1995 each RHA also received funding under a protected envelope, called "Action for Health." This funding initially was offered for a two year period, subsequently extended for another two fiscal years, 1997-98 and 1998-99. Action for Health dollars were earmarked specifically for health promotion activities, and were segregated from the block funding in order to ensure an opportunity for health promotion programming to develop a secure regional basis before being forced to compete with acute and long-term care services for a limited pool of dollars.

At the provincial level, AFH goals included the following: (a) identifying community needs and resources, (b) increasing public participation to identify issues and create solutions, (c) increasing effective partnerships and collaboration between sectors, (d) increasing the number of effective strategies for health promotion. Each region was

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invited to submit proposals for this funding that would address the provincial goals and meet any additional regional health promotion goals desired. All RHAs received some funding from the AFH program, though not necessarily the original amount requested.

More than half of the 17 regions proposed, in some form or another, to place a portion of their AFH money into a community grant fund. This money would then be offered, through a competitive application process, to community groups and agencies that proposed to implement small-scale health promotion projects. The decision to establish a community grant fund appears to have been developed independently by the different health regions.

II. Purpose of this study

Given the number of regions pursuing community grant initiatives, there seemed to be considerable value in comparing the experiences of different regions, to share lessons and perhaps identify some of the most successful processes and the most likely outcomes of such initiatives. The final evaluation report for the first two years of AFH makes the following comment in respect to community grants: "Since the grants process appears to be successful in mobilizing communities to take ownership of their problems and action toward solving them, it would be useful to better understand this process -- how it works in different Regions, and why it works well" (Pro-Health Consulting & Howard Research and Instructional Systems Inc., 1997, p. 12). This study is a first attempt to address this question.

Following a meeting of AFH representatives held in the David Thompson Health Region in August, 1996, an invitation was issued to the different regions to participate in a comparative study of their grant processes. Four regions committed themselves to active participation, and information from these regions forms the basis of this study.

A number of questions related to the process and outcomes of the different AFH projects were developed. Each of the participating regions undertook to answer these questions, using a combination of methods such as a review of program materials, discussions with staff, and interviews with community members who received funding.

III. Theory of Community Grants

Non-profit agencies like the United Way, as well as various community foundations, have a long history of supporting community projects with both one-time and continuing grant funding. One such initiative in the U.S. with a specific health promotion orientation is the Kaiser Family Foundation's Community Health Promotion Grants Program. There is considerable literature available in relation to this initiative as a whole (Tarlov et al., 1987; Cheadle et al., 1997), as well as to some of the individual projects that it supported (Cheadle et al., 1994; 1995a; 1995b). However, this initiative

involved substantially greater sums of money than those available to Alberta RHAs: $150,000/year for each funded community groups. It may not be the best guide in understanding the dynamics of more limited project funding.

Closer to the nature of the Alberta experience are some published reports of health promotion-focused community grant projects sponsored by academic institutions in the US. Forster-Cox, Wiese, & MacLean (1996) report on health promotion mini-grants provided by the University of New Mexico, while Paine-Andrews, Francisco, & Fawcett (1994) describe a microgrant project launched by the Work Group on Health Promotion and Community Development at the University of Kansas.

There are as well a number of examples of government departments and agencies that have experimented with community grant processes. A territory-wide program has operated in the past in the Yukon (Matthias, 1994). A recent evaluation study describes some of the projects supported in Oregon by that state's Office of Disabilities Prevention (Larson Debar, 1997). In Alberta, the provincial Office of the Commissioner of Services for Children and Families has been responsible for a number of community grants under the Early Intervention Program.

Overall though, despite the many groups and agencies that have adopted competitive community grant funding processes, there is little published evaluation literature and little evidence that such initiatives are based upon sound theoretical footing or the lessons of prior experience.

IV. Why Community Grants

The expressed purpose of the community grant initiative in the different health regions, in one way or another, reflect the idea of increasing public participation in decision-making about health programming.

- "to facilitate community involvement in identifying issues and creating solutions"
- "Individuals and agencies within the RHA will work together towards addressing identified needs"
- "to enable communities to take responsibility for their health and create supportive environments to encourage positive change in health behaviours"
- "to give residents of the Region an opportunity to become involved in addressing health issues"

Regions also indicated that the development of grants program was an attempt to respond to the request of community representatives consulted during development of AFH proposals for more input into decision-making. Community members reported that they had many ideas about actions that could be taken to improve health, but that they lacked means of putting such ideas into effect.

There is no evidence among the Regions consulted, however, that the idea of a

community grants process was directly based upon any explicit theory of how such a process effectively contributes to improved health, or that the experiences of others as reported in the literature was studied.

V. What got funded

The table below summarizes community grant initiative funding for the participating Regions.

Region	Total AFH $	$ Allotted to Grants	No. of Applications	Disposition of Applications
Three	149,175	96/97: 32,000[2]	Rd 1: 24 Rd 2: 13	7 funded 7 funded
Six	274,500	96/97: 120,000	44	17 funded
Eleven	308,400	96/97: 63,100	36	20 funded
Thirteen	171,755	96/97: 90,000	57	35 funded

The maximum grant amount available to community initiatives varied among regions between $4000 and $10,000. Actual amounts received by funded projects ranged from $300 to $10,000. Some projects (the 63% reported in one Region may or may not be typical) supplemented their AFH support with their own resources, or resources from partners and other funders, a result desired or expected in all RHAs. The expressed view among regions as to the rationale behind the limitation on grants was that it would enable smaller organizations to compete with more established and professional ones for funding, and it would encourage partnerships among different groups. An effect of smaller grant amounts indeed appears to be projects that were more localized in geographic and demographic scope, and which relied more upon volunteer effort. Larger grant amounts enabled projects to be more ambitious, and often resulted in the funding of full- or part-time coordinator positions to oversee the community-based project. There is also some possibility that the size of grants was influenced by political criteria of ensuring that funding could be widely distributed among different geographic parts of the RHAs.

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[2] A total of $60,000 was originally allocated; the balance was carried over into the following fiscal year.

An analysis of the application criteria developed in the different RHAs suggests the following in regard to the nature of the projects that were sought. Involvement of community members and/or target groups in developing proposals was clearly sought. There was an emphasis upon partnerships and collaboration among community groups. Groups were expected to plan both for evaluation and sustainability beyond one-year funding from the RHA. At least initially, however, the content or focus of community projects was not directed by the Regions.

The projects that were actually funded can be categorized in a number of different ways. Two of the most revealing are around the determinants of health which were the central focus of projects, and the nature of projects on a continuum from health education to collective political action (as, for instance, Labonte, 1995).

In all regions, the majority of projects were focused upon lifestyle and behaviour choices, personal coping skills, and social support. Typical examples include the funding of school or youth counsellor positions, parenting programs, injury awareness projects, suicide prevention, or youth leadership development. Far fewer projects were funded whose major focus was upon such determinants of health as the physical environment, employment, working conditions, or income and social status.

Similarly, the vast majority of programs could best be characterized as health education and/or awareness, including workshops, training sessions, and the development of resource materials. There were some projects focused upon support groups and counselling. None of the funded projects in the RHAs under study appeared to be primarily concerned with political action, or policy advocacy.

VI. Process

The nature of the application and funding process developed in the RHAs varies on many different points, which makes a systematic comparison difficult. Therefore, two aspects of the process were selected for discussion here, based upon their centrality to the conduct of the granting in all Regions. These aspects are, first, the composition of the decision-making body and its decision processes, and second, the nature of support or assistance provided by RHAs to grantees during the application process and subsequently through the implementation and evaluation phases of each community-based project.

Decision-making

There were some considerable differences in the nature of the selection committee established in each RHA. One region used a committee of community and public health service managers. Another used a committee on which the majority of the members were from the community. The third RHA had a committee with a mix of staff, community members, and outside agency members; this committee had an advisory function only, with the final decision in the hands of AFH staff. Finally, the fourth region

had its selection made by the committee established by the Steering Committee of the Children and Family Services authority for its own Early Intervention Project grants. The RHA had 2 representatives among 16 on this committee.

Training and Support

All of the regions provided support to applicants in the initial stages of the process. This consisted primarily of workshops on proposal writing and/or one-to-one facilitation assistance to applicants. Some Regions also organized opportunities to bring participants in funded projects together to share their experiences. No Region was able to spell out the theory or logic upon which its approach was designed, however.

The grant process in the David Thompson Health Region made extensive use of community facilitators assigned to work with projects over the duration of their funding period. Particular attention was paid to evaluating this aspect of the process. Key findings were that the community members appreciated the presence of trained facilitators, and found them useful as catalysts for action and/or sounding boards. Facilitators were also perceived by grantees as people who could advocate on their behalf with the Regional bureaucracy.

An important facet of support that seemed common among regions was assistance in evaluation. Applicants were expected to develop evaluation plans in their application. In some Regions, they were later required to meet with evaluators and to carry out certain evaluation tasks meeting the needs of AFH staff, while also conducting any evaluation that met the needs of their own planning. While the grant process appears to assist in developing evaluation skills among community groups, it is also clear that this is an area in which further work is required.

RHAs report that they attempted wherever possible to refer unsuccessful applicants to other potential funding sources, but little other assistance appears to have been offered. The original intention of the AFH program in the David Thompson Health Region was to continue to provide some degree of on-going facilitation and support to unsuccessful applicants, but program time and resource constraints made this impossible to carry through.

VII. Outcomes

Each of the regions required somewhat different processes of outcome evaluation from funded projects, that is, the assessment of the overall impact of the community grants as a health promotion strategy. However, the findings can be addressed in three general categories: impacts upon health and the determinants of health, increases in the capacity or ability of the community to address health concerns, and increases in partnership and collaboration among different groups, sectors and persons.

Given the short time-frames within which funded projects were expected to operate, it is not reasonable to expect them to result in measurable changes to traditional indicators of community health status, such as suicide rates, low birth weight babies, teen pregnancy, or injury morbidity. Community members repeatedly stressed this point. Nonetheless, they were confident that their activities were having an impact upon some of the factors which determine health. More than one RHA provided evidence from interviews with participants about such changes as increased social interaction, increased self-esteem or self-worth, certain changes to behavioural patterns such as diet, exercise, or tobacco use.

Community projects were more able to describe some of the ways in which their actions had expanded the capacity of the community and its members to address their health concerns. The creation of new information resources, as well as training and skill development opportunities, were repeatedly cited. Organizational and leadership skills were strengthed among many of those most active in planning and carrying out community projects. The RHA staff most closely involved in the community grants processes welcomed these findings as evidence of success, but remain aware of the need to more clearly demonstrate how increased community capacities lead to improved community health.

In a number of cases projects were able to report increases in partnering, and the creation of linkages among agencies and groups that had previously not had occasion to work together. Other community groups emphasized that they had long-standing and wide-spread community connections to draw upon, and that their projects would reinforce or strengthen these links. On the other hand, all Regions observed some instances in which the concept of "meaningful," or "contributing" partners proved difficult for applicants to realize. Not every project was able to go beyond that idea that a letter of support for an application was equivalent to an active partnership.

Sustainability proved to be a difficult outcome for projects to attain, despite their advance knowledge that RHA funding was limited to a one-year period. Perhaps typical is the report from one Region that, while 39% of its funded projects were pursuing other sources of support, only 14% had this support arranged by the final evaluation period.

Some factors appeared to be welcomed by the community across all regions, regardless of the fine details of the process, and some factors were likewise criticized. Support in preparing applications was well received, and application processes were generally clear and understandable for the community. Evaluation requirements, by contrast, were often felt to be repetitive and excessive.

Project coordinators across all regions generally reported that projects either would not have proceeded without assistance from AFH community grants, or that they would have only been able to go ahead in reduced form.

VIII.Conclusions

Community grant programs in Alberta RHAs have demonstrated themselves to be popular with the public. This is not necessarily the same as being an effective strategy for community health promotion. We can identify some ways in which hey have brought benefit to Regional populations, most especially in terms of increasing skills, capacities and resources. However, more rigourous evaluation is required in order to further elaborate the theoretical underpinnings of the community grants approach and to use such findings to develop more rigourous evaluation strategies.

Many questions suggest themselves as fruitful opportunities for future research. For instance, are there significant differences in decision-making processes and results between a selection committee with a majority of community members and one in which all members are health professionals or RHA staff? Another question concerns the composition of groups coming forward with proposals -- did they reflect the concerns and needs of the community as a whole?

It would also be valuable to have additional information about the sustainability of projects funded during the 1996-97 period. Only one of the four Regions reports any intention of doing further follow-up to assess how many projects continue to operate, and under what circumstances. Without such work, however, we cannot know if a community grant approach results in more than a temporary change in the community conditions that influence or determine health.

Despite these caveats, all the Regions participating in this study have continued to engage in a community granting process of one form or another. Given the many differences in approach among the RHAs, it is difficult to say anything definite about best practices. The most clear finding is that support and guidance to applicants is both appreciated by community members and helps them implement their projects more successfully. Further research on the different forms which such support can take would help to indicate how maximum benefits might be achieved through targeted use of Regional human resources.

Finally, the fact that each RHA has adapted or modified its grant program, based upon the learnings of the first year should be encouraging to those who believe that evaluation findings have a significant and important role in informing and improving practice.

IX. References

Cheadle, A. et al. (1994). Relationship Between Socioeconomic Status, Health Status, and Lifestyle Practices of American Indians: Evidence from a Plains Reservation Population. Public Health Reports, 109:3. 405-13.

Cheadle, A., et al. (1995a). Evaluating Community-based Nutrition Programs: Comparing Grocery Store and Individual-level Survey Measures of Program Impact. Preventive Medicine, 24:1. 71-79.

Cheadle, A., et al. (1995b). A Community-based Approach to Preventing Alcohol Use Among Adolescents on an American Indian Reservation. Public Health Reports, 110:4. 439-47.

Cheadle, A., et al. (1997). Conference Report: Community-based Health Promotion -- State of the Art and Recommendations for the Future. American Journal of Preventive Medicine, 13:4. 240-43.

Forster-Cox, Susan, William Wiese, & Thomas MacLean. (1996). Health Promotion Mini-grants: Grassroots Implementation in New Mexico. American Journal of Health Promotion, 10:3. 183-84.

Labonte, Ron. (1995). Health Promotion and Empowerment: Practice Frameworks. Centre for Health Promotion, University of Toronto. Issues in Health Promotion Series #3.

Larson DeBar, Lynn. (1997). The Evaluation of a Community Initiatives Mini-Grants Program: Project Implementation and Evaluation Challenges in Grass Root Settings. Roundtable presentation at the American Evaluation Association Annual Meeting, San Diego.

Matthias, Sharon. (1994). Health Promotion in the Yukon Territory. In Health Promotion in Canada: Provincial, National and International Perspectives. Ann Pederson, Michel O'Neill, Irving Rootman, eds. Toronto: W.B. Saunders Canada. 206-225.

Paine-Andrews, Adrienne, Vincent Francisco, & Stephen B. Fawcett. (1994). Assessing Community Health Concerns and Implementing a Microgrant Program for Self-Help Initiatives. American Journal of Public Health, 84:2. 316-18.

Pro-Health Consulting & Howard Research and Instructional Systems Inc. 1997. Action for Health Evaluation: Year Two Final Report.

Tarlov, A.R. (1987). Foundation Work: The Health Promotion Program of the Henry J. Kaiser Family Foundation. American Journal of Health Promotion, 2. 74-80.